Mass General Brigham
Health Plan

Plan Exclusions
Effective 06/05/2023

Plan	☒ MassHealth UPPL ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☒ Medical Benefit (NLX)		
Specialty Limitations	N/A		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview

The purpose of this guideline is to clarify the procedures for evaluating prior authorization requests for the following requests that are generally excluded from coverage:

- Cosmetic/hair growth agents
- Agents for the symptomatic relief of coughs and colds
- Fertility agents
- Obesity management (weight loss) agents
- Less than Effective Drugs: Drug Efficacy Study Implementation (DESI) drugs
- Experimental and investigational drugs
- Sexual dysfunction agents

Require PA
Cosmetic Medications
Avage® (tazarotene) 0.1% cream
Botox Cosmetic® (onabotulinum toxin A) 50 unit, 100 unit vial
Chromelin® complexion blender (dihydroxyacetone) 5% solution †
Daxxify ® (daxibotulinumtoxina-lanm)
Eskata® (hydrogen peroxide) 40% solution †
hydroquinone powder †
hydroquinone, topical (single or combination product)
Jeuveau® (prabotulinumtoxinA-xvfs) †
Kinerase® (kinetin) 0.1% lotion, 0.1% cream, 0.125% cream
Kybella (deoxycholic acid) †

Latisse® (bimatoprost) 0.03% solution mequinol crystals † monobenzone powder † Pliaglis (lidocaine/tetracaine) 7%/7% cream Propecia® (finasteride) 1 mg tablet Refissa® (tretinoin/emollient) 0.05% cream † Renova® (tretinoin/emollient) 0.02% cream Rogaine® (minoxidil) 2% solution, 5% solution, 5% foam † Qwo® (collagenase clostridium histolyticum-aaes) Vaniqa® (eflornithine) 13.9% cream
Cough and Cold
There are a large number of cough and cold agents that require PA. If the request designates that the agent is used for the symptomatic treatment of cough or cold symptoms it would be considered excluded by regulations.
Fertility
Bravelle® (urofollitropin) 75 unit vial Cetrotide® (cetrorelix) 0.25 mg kit chorionic gonadotropin 6,000 unit, 12,000 unit vial clomiphene 50 mg tablet, powder Crinone® (progesterone) 8% gel Endometrin® (progesterone) 100 mg suppository Follistim AQ® (follitropin beta) 75 unit, 150 unit vial, 300 unit, 600 unit, 900 unit cartridge First®-Progesterone (progesterone) 25 mg , 50 mg, 100 mg, 200 mg, 400 mg suppository † ganirelix 250 mcg/0.5 mL syringe Gonal-F® (follitropin alfa) 75 unit vial, 300 unit pen, 450 unit pen, 450 unit vial, 900 unit pen, 1,050 unit vial Luveris® (lutropin) 75 unit vial Menopur® (menotropins) 75 unit vial Novarel®, Pregnyl® (chorionic gonadotropin) 10,000 unit vial Ovidrel® (choriogonadotropin alfa) 250 mcg/0.5mL syringe Repronex® (menotropins) 75 unit vial
Obesity Management (weight loss)
Alli® (orlistat) 60 mg capsule Adipex-P® (phentermine) 37.5 mg capsule, 37.5 mg tablet Belviq (lorcaserin) 10 mg tablet Belviq XR (lorcaserin) 20 mg tablet Bontril PDM® (phendimetrazine) 35 mg tablet Contrave® (bupropion/naltrexone) 8 mg-90 mg tablet Didrex® (benzphetamine) 50 mg tablet diethylpropion 25 mg tablet diethylpropion ER 75 mg tablet Optifast® (dietary supplement) 70 powder packet † phendimetrazine ER 105 mg tablet phentermine 15 mg, 30 mg capsule phentermine powder † Plenity (carboxymethylcellulose/citric acid) capsule† Qsymia® (phentermine/topiramate) 3.75 mg-23 mg, 7.5 mg-46 mg, 11.25 mg-68 mg, 15 mg-92 mg capsule Resveratrol® (dietary supplement) 50 µg/20 µg capsule

Saxenda® (liraglutide [rDNA origin]) injection Suprenza ODT® (phentermine) 15 mg, 30 mg, 37.5 mg tablet Wegovy (semaglutide) 0.25 mg/0.5 mL pen, 0.5 mg/0.5 mL pen, 1 mg/0.5 mL pen, 1.7 mg/0.75 mL pen, 2.4 mg/0.75 mL pen Xenical® (orlistat) 120 mg capsule
Experimental or investigational drugs
All drugs deemed to be experimental or investigational in nature require prior authorization.
Sexual Dysfunction
Addyi® (flibanserin) 100 mg tablet alprostadil/papaverine † alprostadil/phentolamine † alprostadil/papaverine/phentolamine † bremelanotide acetate powder † Caverject Impulse® (alprostadil) 10 µg kit and syringe, 20 µg kit and syringe, 20 µg vial, 40 µg vial, 40 µg/2 mL ampule Cialis® (tadalafil) 2.5 mg, 5 mg, 10 mg, 20 mg tablet Edex® (alprostadil) 10 µg, 20 µg, 40 µg cartridge Imvexxy® (estradiol) 4 µg, 10 µg vaginal insert † Intrarosa® (prasterone) 6.5 mg vaginal insert Levitra® (vardenafil) 2.5 mg, 5 mg, 10 mg, 20 mg tablet Muse® (alprostadil) 125 µg, 250 µg, 500 µg, 1,000 µg urethral suppository Osphena® (ospemifene) 60 mg tablet Staxyn® (vardenafil) 10 mg ODT Stendra® (avanafil) 50 mg, 100 mg, 200 mg tablet Viagra® (sildenafil) 25 mg, 50 mg, 100 mg tablet Vyleesi® (bremelanotide) 1.75 mg/0.3 mL autoinjector yohimbine 5.4 mg tablet

*This list is not considered to be all-inclusive.

†These agents do not participate in the Federal rebate program. The principles of reviewing a non-rebate medication would apply.

Coverage Guidelines

Authorization may be granted for members when all the following criteria are met, and documentation is provided:

1. Agents used for the purposes listed above are excluded from coverage by MassHealth regulations. For agents that may have other non-cosmetic, non-cough/cold, non-fertility, non-weight management, or non-sexual dysfunction indications will be evaluated on a case-by-case basis for medically necessity.

Continuation of Therapy

Reauthorization requires physician documentation of a therapeutic response to treatment.

Limitations

1. Initial approvals and reauthorizations will be granted for 1 year

References

N/A

Review History

02/08/2023 - Reviewed and created for Feb P&T; Matched MH UPPL criteria to be in compliance with Masshealth unified formulary requirements. Effective 4/1/23.
05/10/23 – Reviewed and updated for P&T. Daxxify ® (daxibotulinumtoxina-lanm) and Qwo® (collagenase clostridium histolyticum-aaes) will be excluded from coverage due to cosmetic indication. Effective 6/5/23.